

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5335

CERTIFICATE OF DEATH

05287
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Children's Center		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
f. STREET ADDRESS 766 Irving Street, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Armstrong, Jr.		4. DATE OF DEATH Month May Day 23 Year 1960	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1944
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 60	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Edward Armstrong		14. MOTHER'S MAIDEN NAME Grace Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Children's Center, Laurel, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Muscular dystrophy 744.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mental retardation DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 11, 1960 to May 23, 1960 , that I last saw the deceased alive on May 23, 1960 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Boyland M.D.		ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 5/23/60	
PHYSICIAN'S NAME (Type) James E. Boyland, M.D.		Children's Center, Laurel, Md. 5/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard E. Beale		24. REGISTRAR'S SIGNATURE Charles L. Kline	

1820 9th St NW

REC'D BY REGISTRAR
DATE **MAY 25 '60**

100-4-10

CENTRAL AIRCRAFT

100-4-10



100-4-10

100-4-10

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100-4-10

CERTIFICATE OF DEATH

05288

Reg. Dist. No.

5331

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Briarwood Beach</i>		c. LENGTH OF STAY IN 1b <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lily First Josephine Artes Middle Last</i>		4. DATE OF DEATH Month <i>May</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 4, 1876</i>
9. AGE (In years lost birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months <i>83</i> Days <i>83</i> Hours <i>83</i> Min.	11. IF UNDER 24 HRS. Months <i>83</i> Days <i>83</i> Hours <i>83</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Newport, Kentucky</i>	
11. BIRTHPLACE (State or foreign country) <i>Newport, Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Ryan</i>		14. MOTHER'S MAIDEN NAME <i>Mary O'Connor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <i>212-14-045</i>	
17. INFORMANT <i>Mrs. Nellie Grose</i>		Address <i>Riviera Beach, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute cardiac decompensation</i> DUE TO <i>arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>cerebro-vascular accident</i> DUE TO (c) <i>13 years</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>October 16, 1954</i> , to <i>May 31, 1960</i> , that I last saw the deceased alive on <i>May 29, 1960</i> , and that death occurred at <i>9:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>3708 Mountain Rd Pasadena, Md.</i>	
DATE SIGNED <i>5/31/60</i>			
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/4/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tucker</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 2 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MRS. J. M. SMITH		65		F		W		JAN 15 1855		BALTIMORE		MD		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 20 1915		HOME		BALTIMORE		MD		USA		JAN 20 1915		HOME		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		NATURAL		JAN 20 1915		HOME		BALTIMORE		MD		USA		JAN 20 1915		HOME	
SIGNATURE OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. M. SMITH		JAN 20 1915		HOME		BALTIMORE		MD		USA		JAN 20 1915		HOME		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. M. SMITH		JAN 20 1915		HOME		BALTIMORE		MD		USA		JAN 20 1915		HOME		BALTIMORE	



THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE PHYSICIAN AND THE REGISTRAR. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FURNISH THE NECESSARY INFORMATION. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FURNISH THE NECESSARY INFORMATION. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FURNISH THE NECESSARY INFORMATION. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FURNISH THE NECESSARY INFORMATION.

5297

CERTIFICATE OF DEATH

05289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edwin Middle E Last BANGERT				4. DATE OF DEATH Month May Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 14, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prob. meat Market				10b. KIND OF BUSINESS OR INDUSTRY Meat Groceries			
13. FATHER'S NAME WILLIAM H. BANGERT				14. MOTHER'S MAIDEN NAME ANNE L SCHNEIDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HILDA L BANGERT Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Artery Disease (c) Gen. Arteriosclerosis & hypertension						INTERVAL BETWEEN ONSET AND DEATH 7 days ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1				20g. (County) 2		20h. (State) 3	
21. I certify that I attended the deceased from Apr. 28, 19 60 , to May 5, 19 60 , that I last saw the deceased alive on May 5, 19 60 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 31 Southgate Ave., DATE SIGNED 5/6/60							
ACTUAL SIGNATURE Maurice Klawans M.D.				PHYSICIAN'S NAME (Type) Maurice Klawans Annapolis, Md.			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF MAY 9-1960		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cent		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md.				24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1937

05250

PLACE OF DEATH		MARRIAGE	
AT HOME		MARRIED	
CITY OR TOWN		CITY OR TOWN	
COUNTY		COUNTY	
STATE		STATE	
DATE OF DEATH		DATE OF DEATH	
HOUR		HOUR	
MINUTE		MINUTE	
DAY OF THE WEEK		DAY OF THE WEEK	
MONTH		MONTH	
YEAR		YEAR	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF SHERIFF		SIGNATURE OF SHERIFF	
SIGNATURE OF CORONER		SIGNATURE OF CORONER	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF DISTRICT ATTORNEY	
SIGNATURE OF COUNTY CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF TOWNSHIP CLERK	
SIGNATURE OF VILLAGE CLERK		SIGNATURE OF VILLAGE CLERK	
SIGNATURE OF CITY CLERK		SIGNATURE OF CITY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF STATE CLERK	
SIGNATURE OF NATIONAL CLERK		SIGNATURE OF NATIONAL CLERK	
SIGNATURE OF INTERNATIONAL CLERK		SIGNATURE OF INTERNATIONAL CLERK	
SIGNATURE OF FOREIGN CLERK		SIGNATURE OF FOREIGN CLERK	
SIGNATURE OF OTHER CLERK		SIGNATURE OF OTHER CLERK	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the medical examiner. TO CHIEF MEDICAL EXAMINER'S Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05298
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>H.A.C.O.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.A.C.O.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - MD</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XARNOLD - MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A - ANNIE ARUNDEL - Gen</u>			d. STREET ADDRESS <u>1 Dogwood Trailon Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>D</u> Last <u>Barge</u>			4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 June 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Barge</u>		
14. MOTHER'S MAIDEN NAME <u>Viola H. Bowers</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT <u>Mrs. Lillian Griffith to 8 Delmar Ave - Glen Burnie, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 4-34-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-15-60</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>18 May 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pr. Longton</u>		ADDRESS <u>Glen Burnie Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

5299

CERTIFICATE OF DEATH

05291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b X Gambrills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Bessie Middle Ann Last Baumgardner				4. DATE OF DEATH Month May Day 28 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63		IF UNDER 24 HRS. Days 63 Hours 63 Min. 63			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Lafayette Hounshell				14. MOTHER'S MAIDEN NAME Mary Hounshell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) Myocardial infarction							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month May Day 28 Year 1960				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Annapolis				(County) Anne Arundel		(State) Md.	
21. I certify that I attended the deceased from July 1955 to May 28, 1960 , that I last saw the deceased alive on May 28, 1960 , and that death occurred at 6:25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Hedeman				DATE SIGNED 6/29/60			
PHYSICIAN'S NAME (Type) John Hedeman MD				ADDRESS (Street, city or town, state) 121 Cathedral			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain the certificate and pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5300

CERTIFICATE OF DEATH

05292

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louise M. BEADLE		4. DATE OF DEATH Month Day Year May 30 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry M. Meixner HENRY M. MEIXNER		14. MOTHER'S MAIDEN NAME ALICE M. NIEMANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT PAUL M. BEADLE #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure (c) Pulmonary Congestion DUE TO (d) Metastatic Carcinoma, ovary 31 mo.		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Cachexia, Anemia, ascites		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1960, to May 30, 1960, that (I) (we) last saw the deceased alive on May 30, 1960, and that death occurred at 9:35 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Stuart M. Christhilf, Jr.		22b. DATE SIGNED 5/31/60	
22c. PHYSICIAN'S NAME (Type) Stuart M. Christhilf, Jr.		22d. ADDRESS 60 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-2-1960	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEM. CEM.		23d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR - SON		25a. REC'D BY REGISTRAR JUN 3 '60	
ADDRESS ANNAPOLIS MD.		25b. REGISTRAR'S SIGNATURE Charles E. Hines	

0388

CERTIFICATE OF DEATH

1910

Name of Deceased: Alice M. Bradley

Age: 45

Sex: Female

Color: White

Married: Yes

Place of Birth: New York

Place of Death: New York

Time of Death: 10:30 AM

Signature of Physician: [Signature]

Signature of Coroner: [Signature]

Signature of Registrar: [Signature]

Signature of Burial Officer: [Signature]

Signature of Undertaker: [Signature]

Signature of Witness: [Signature]

Signature of Minister: [Signature]

Signature of Clerk: [Signature]

Signature of Deputy Clerk: [Signature]

Signature of Health Officer: [Signature]

Signature of Medical Examiner: [Signature]

Signature of Coroner: [Signature]

5301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> <u>Henry</u> <u>Blades</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freeze Boxes</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. H. Blades</u>		14. MOTHER'S MAIDEN NAME <u>Georgina Harrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Georgina McKinney</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>MAY 2 / 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-5-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylors Sons Annapolis Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>MAY 6 '60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the funeral home. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6536

5302

CERTIFICATE OF DEATH

05294

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>55 Spa Road</u>				d. STREET ADDRESS <u>55-SPA ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMANDA Ayres Booth</u>				4. DATE OF DEATH Month Day Year <u>5 6 19 60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 31 - 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM Ayres</u>				14. MOTHER'S MAIDEN NAME <u>MARIAH - Maiden: Name Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>JAMES H. Booth - 808 Spa Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease Gr. IV</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/21</u> , 19 <u>60</u> , to <u>5/6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>60</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>37 Calvert St., Annapolis, Md.</u> DATE SIGNED <u>5/7/60</u>							
ACTUAL SIGNATURE <u>Theodore H. Johnson M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u> ADDRESS <u>ANNAPOLIS - Md</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be verified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IVA</u> Middle <u>IRENE</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Deale, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lum Rodgers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Whittington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Milfred W. Brown, Husband— same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Coronary Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>49</u> , to <u>19 May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>19 May</u> , 19 <u>60</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.B. Sasser</u>		DATE SIGNED <u>20 May 60</u>	
PHYSICIAN'S NAME (Type) <u>R.B. SASSER MD</u>		ADDRESS (Street, city or town, state) <u>UPPER MARLBORA, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 23, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Methodist Cemeter.</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Zion, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

CERTIFICATE OF DEATH

X

X

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG264 6-13-60 et

5303

CERTIFICATE OF DEATH

05296
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. Ad.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad. Ad.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Davidsonville Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Brown</u> Middle <u>Brown</u> Last				4. DATE OF DEATH <u>5</u> Month <u>22</u> Day <u>1960</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-5-1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Brown</u>			
14. MOTHER'S MAIDEN NAME <u>Rosie Mitchell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>218-129654</u>				17. INFORMANT <u>Orabutter Davidsonville Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Hypertension Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 mos.</u> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>1</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/22</u> , 19 <u>60</u> , to <u>5/22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>37 Cedar Street</u>			
DATE SIGNED <u>May 26 '60</u>				PHYSICIAN'S NAME (Type) <u>Dr THEODORE H. JOHNSON</u> <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>MAY 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

CERTIFICATE OF DEATH

2803

<p>1. NAME OF DECEASED [Handwritten: <i>John Doe</i>]</p>		<p>2. SEX [Handwritten: <i>Male</i>]</p>		<p>3. AGE [Handwritten: <i>45</i>]</p>		<p>4. DATE OF DEATH [Handwritten: <i>Jan 15 1920</i>]</p>	
<p>5. PLACE OF DEATH [Handwritten: <i>Home</i>]</p>		<p>6. CAUSE OF DEATH [Handwritten: <i>Heart Disease</i>]</p>		<p>7. MANNER OF DEATH [Handwritten: <i>Natural</i>]</p>		<p>8. PLACE OF BIRTH [Handwritten: <i>MD</i>]</p>	
<p>9. OCCUPATION [Handwritten: <i>Teacher</i>]</p>		<p>10. MARITAL STATUS [Handwritten: <i>Married</i>]</p>		<p>11. COLOR [Handwritten: <i>White</i>]</p>		<p>12. RELIGION [Handwritten: <i>Protestant</i>]</p>	
<p>13. SIGNATURE OF PHYSICIAN [Handwritten: <i>Dr. J. Smith</i>]</p>		<p>14. SIGNATURE OF REGISTRAR [Handwritten: <i>W. Jones</i>]</p>		<p>15. SIGNATURE OF WITNESSES [Handwritten: <i>John Doe, Mary Doe</i>]</p>		<p>16. SIGNATURE OF DECEASED [Handwritten: <i>John Doe</i>]</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW YORK. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF PENNSYLVANIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MINNESOTA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WISCONSIN. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IOWA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEVADA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW MEXICO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEVADA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW MEXICO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5337

CERTIFICATE OF DEATH

05297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 4 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>District Training School Children's Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joyce</u> Middle <u>Aletha</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/11/58</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Walter James Brown</u>		14. MOTHER'S MAIDEN NAME <u>Viola Rumsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT Address <u>Children's Center, Laurel, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> DUE TO <u>Meningomyelocele</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>751X</u> (c) <u>751X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>22 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>--</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 15, 1959</u> , to <u>May 4, 1960</u> , that I last saw the deceased alive on <u>May 4, 1960</u> , and that death occurred at <u>4:30 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Boyland, M.D.</u>		ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>5/4/60</u>	
PHYSICIAN'S NAME (Type) <u>James E. Boyland, M.D.</u>		<u>Children's Center, Laurel, Md.</u> <u>5/4/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 6 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>School District Training</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Webster District Training Sch.</u>		24a. REC'D BY REGISTRAR <u>May 9 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

STATE OF DEATH

1900

1

1900

1

1900

1900

1900

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5338

CERTIFICATE OF DEATH

05298
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b 15 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crain Highway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Wardell Last Brundrett, Sr.				4. DATE OF DEATH Month 5 Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1887	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tube Maker				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore County	
13. FATHER'S NAME John Brundrett				14. MOTHER'S MAIDEN NAME A. Bolton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none				16. SOCIAL SECURITY NO. 216-20-0962		17. INFORMANT Mrs Elmyra Brundrett, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung Rt. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 Mos.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from March , 19 53 to May , 19 60 , that I last saw the deceased alive on May 19 , 19 60 , and that death occurred at 10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. B. McDonald M.D.				ADDRESS (Street, city or town, state) 204 Crain Hwy SW		DATE SIGNED 5-21-60	
PHYSICIAN'S NAME (Type) Ishen Burnie M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
				24b. REGISTRAR'S SIGNATURE C. L. S. Hines			

RECEIVED
JAN 10 1900

CERTIFICATE OF DEATH

1900

1. Name of deceased: John Brown

2. Age: 45

3. Sex: Male

4. Date of death: Jan 10 1900

5. Place of death: At home

6. Cause of death: Heart disease

7. Signature of physician: Dr. J. H. Smith

8. Signature of witness: Wm. J. Brown

9. Signature of registrar: John D. Brown

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5304 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05299.
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> <u>Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>1 THOMPSON AVE. SEVERN</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H</u> Last <u>Buddenbohm</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-20-92</u>	
				9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSE KEEPER (Ret.) West-Md. R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis H. Buddenbohm</u>				14. MOTHER'S MAIDEN NAME <u>Christine (Unknown) SEVERN, Md</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>WIFE</u>		Address <u>THOMPSON AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer Linhardt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ELMER LINHARDT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10 May 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. E. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 16 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>	

DATE SIGNED

5/7/1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5339

CERTIFICATE OF DEATH

05300

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>District Training School Children's Center</u>		d. STREET ADDRESS <u>1602 E Street S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Odessa</u> Middle _____ Last <u>Butler</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/34</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>institutionalized</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilson N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Marie Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Children's Center, Laurel, Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mental retardation</u> DUE TO (c) <u>Epilepsy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>October</u> , 19 <u>54</u> , to <u>May 31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>60</u> , and that death occurred at <u>10:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Margaret W. Mola</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Margaret W. Mola, M.D.</u>		<u>Children's Center, Laurel, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 3, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>District Tng School</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Delabster Asst Supt D.T.S.</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

5340

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>409 Nancy</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Randolph</u> Last <u>Carey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 '28</u>		9. AGE (In years last birthday) <u>31</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Installment Operators Inc</u>		11. BIRTHPLACE (State or foreign country) <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Wesley D. Carey</u>				14. MOTHER'S MAIDEN NAME <u>Julia Jarrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>227-22-8616</u>		17. INFORMANT Address <u>Betty J. Carey - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>5/12/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>5/12/60</u> , 19 <u> </u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. d. Ball Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Linthicum Md</u>		DATE SIGNED <u>5/12/60</u>	
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>16th May 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>				ADDRESS <u>Glen Burnie Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5341

CERTIFICATE OF DEATH

05302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRVIEW BEACH</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRVIEW BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01.4	
d. STREET ADDRESS <u>1909 Christian St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>John</u> Last <u>CARRIGAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 23, 1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OIL BURNER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>GEORGE CARRIGAN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH THELEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>217-01-6998</u>	
INFORMANT Address <u>SELMA CARRIGAN 1909 Christian St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>Arteriosclerotic Cardiac-Vascular D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>_____</u> (c) <u>_____</u>			INTERVAL BETWEEN ONSET AND DEATH <u>_____</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>_____</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>	20f. (City or town) (County) (State) <u>_____</u>
21. I certify that I attended the deceased from <u>Oct 27</u> , 19 <u>57</u> , to <u>May 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>60</u> , and that death occurred at <u>6:45 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert Scagnetti</u> M.D.		ADDRESS (Street, city or town, state) <u>1729 W Lombard St</u> DATE SIGNED <u>_____</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT SCAGNETTI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-19-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u> ADDRESS <u>Francis W. Miller 2101 Frederick Ave.</u>		24a. REC'D BY REGISTRAR <u>MAY 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5342 **CERTIFICATE OF DEATH** **05303**

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Round Bay				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Round Bay			
d. STREET ADDRESS /				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LINWOOD Middle LEAVITT Last CARTER				4. DATE OF DEATH Month May Day 14 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1879		9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ithiman M. Leavitt				14. MOTHER'S MAIDEN NAME Mary F. Stubbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-03-7285		17. INFORMANT Mr. Thomas L. Carter - Round Bay, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Metastasis to the Lungs DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. May 14 19 60 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 19 60 to May 19 60 , that (I) (we) lost saw the deceased alive on May 12 19 60 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Francis I. Codd				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.				22d. ADDRESS Severna Park, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17, 1960		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION (City, town, or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickener & Sons - Balt 17 Md				25a. REC'D BY REGISTRAR MAY 17 '60		25b. REGISTRAR'S SIGNATURE Charles E. Thomas	

00303

CENTRAL BANK OF INDIA

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5343

CERTIFICATE OF DEATH

05304
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bristol</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Cleveland Chaney</u> First Middle Last		4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 15 1887</u>
9. AGE (In years, lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt. HARMONY MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Samuel Chaney</u>		14. MOTHER'S MAIDEN NAME <u>Mary Faust</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213 384341</u>	
17. INFORMANT <u>Mrs. Marnie Brady</u> Address <u>RF 2 Upper Marlboro Box 2815 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intermittent C.V.P. Unseen</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1948</u> to <u>8 May 1960</u> , that I last saw the deceased alive on <u>6 May 1960</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. B. Jasser</u>		DATE SIGNED <u>8 May 60</u> ADDRESS (Street, city or town, state) <u>Upper Marlboro, Md.</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard O. Hardesty</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 12 '60</u>	
ADDRESS <u>Salisbury Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5344

CERTIFICATE OF DEATH

Reg. Dist. 05305

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Terrace Gardens</u>			c. LENGTH OF STAY IN 1b 			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Terrace Gardens x Arnold Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Arnold P.O.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>M. Chitwood</u> Last <u>K.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1916</u>		9. AGE (In years last birthday) <u>44</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Yeoman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter M. Chitwood Sr.</u>				14. MOTHER'S MAIDEN NAME <u>BEATRICE Tiblow</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ELEANOR B. Chitwood</u> Address <u>#2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>yes</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 yr.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> to <u>May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>60</u> , and that death occurred at <u>5:25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>5/13/60</u> ACTUAL SIGNATURE <u>John M. Saylor</u> M.D. PHYSICIAN'S NAME (Type) <u>John M. Saylor</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 16-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5305
CERTIFICATE OF DEATH

05306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY U. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brownswood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Rt. 4-Box 3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Kise First Columbia Middle Cook Last		4. DATE OF DEATH Month May Day 7 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1897
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Cook		14. MOTHER'S MAIDEN NAME Harned Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Jane Cook		Address Rt. 4-Box 3-Annapolis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) intestinal obstruction 550.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) following surgery - appendectomy peritonitis and wound dehiscence DUE TO (c) Acute suppurative appendicitis		INTERVAL BETWEEN ONSET AND DEATH 4 days 18 days 19 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 17, 1960 to May 7, 1960 , that I last saw the deceased alive on May 6, 1960 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Richardson		ADDRESS (Street, city or town, state) 110-Clay Street	
PHYSICIAN'S NAME (Type) Dr. R. L. Richardson		DATE SIGNED 5/8/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-1960	
22c. NAME OF CEMETERY OR CREMATORY Broadneck		22d. LOCATION (City, town, or county) (State) Shidmore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Beesett		ADDRESS Annapolis Md.	
24a. REC'D BY REGISTRAR MAY 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

2300

81

1. PLACE OF DEATH Home		2. SEX Male	
3. AGE 65		4. OCCUPATION Retired	
5. MARITAL STATUS Married		6. RACE White	
7. DATE OF DEATH 10/15/1967		8. TIME OF DEATH 10:00 AM	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED John Doe		12. SIGNATURE OF WITNESS Jane Doe	
13. SIGNATURE OF PHYSICIAN Dr. Smith		14. SIGNATURE OF CORONER Mr. Jones	
15. SIGNATURE OF REGISTRAR Mrs. Brown		16. SIGNATURE OF CLERK Miss White	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

2. The cause of death should be stated in as much detail as possible, and should include the immediate cause, the underlying cause, and any other causes which may have contributed to the death.

3. The manner of death should be stated as either natural, accidental, or homicide.

4. The signature of the physician or coroner must be in ink, and must be accompanied by the official seal of the office.

5. The signature of the Registrar must be in ink, and must be accompanied by the official seal of the office.

6. The signature of the Clerk must be in ink, and must be accompanied by the official seal of the office.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5306

CERTIFICATE OF DEATH

05307
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b X RURAL - Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS Rt-4, Box-712, Mulberry Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Mary		Middle Jane		Last COOK	
4. DATE OF DEATH May		Month May		Day 26		Year 19 60	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John S. Hunt				14. MOTHER'S MAIDEN NAME Charlotte Henson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT John Hunt Rt. 4, Annapolis	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Hypertensive Carditis DUE TO (c) Thrombotic disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1959 to May 1960 , that I last saw the deceased alive on May 24, 1960 , and that death occurred at 2:35 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 Clay St., Annapolis, Md. DATE SIGNED 5/27/60							
ACTUAL SIGNATURE R. L. Richardson				M.D. 110 Clay St., Annapolis, Md.			
PHYSICIAN'S NAME (Type) R. L. Richardson				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-29-1966		22c. NAME OF CEMETERY OR CREMATORY Broadneck		22d. LOCATION (City, town, or county) (State) St. Margaret's Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 W. Wash. St. Annapolis				24. REC'D BY REGISTRAR MAY 31 '60		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

50520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5307

CERTIFICATE OF DEATH

05308
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAYO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u>		d. STREET ADDRESS <u>BEVERLY BEACH</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>PEARL</u> Last <u>CORPREW</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-64 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carrison STOCKMAN</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DAUGHTER: MRS. V. LINTON</u>		Address <u>BEVERLY BEACH, MAYO, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4220</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1630 5-22</u> , 19 <u>60</u> , to <u>0558 5-28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>0400 5-28</u> , 19 <u>60</u> , and that death occurred at <u>0558 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>F. W. Kennedy, M.D. for R.A. Botta</u> M.D. <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u> PHYSICIAN'S NAME (Type) <u>R. A. BOTTA LT MC USNR</u> <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sam</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5345

CERTIFICATE OF DEATH

05309

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs d. STREET ADDRESS 6185 Allentown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillie Middle Cotton Last Cotton		4. DATE OF DEATH Month 5 Day 11 Year 1960			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1900	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 5 Days 11 Hours 16 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO Arteriosclerotic Hypertensive Cardiovascular Disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia and Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. 5 p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----		20g. (County) -----		20h. (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 5/3 19 60 to 5/11 19 60 that (I) (we) last saw the deceased alive on 5/11 19 60 , and that death occurred at 4:45 P. M. from the causes and on the date stated above.					
22a. SIGNATURE Hildegard Heard Reissman		M.D. Hildegard Heard Reissman, M.D.		22b. DATE 5/12/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 5/17/60		23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony	
23d. LOCATION (City, town, or county) Prince Georges County Md.		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines + Co.		ADDRESS 3015 - 12th St. N.E.		25a. REC'D BY REGISTRAR MAY 16 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines					



2322

CERTIFICATE OF DEATH

02319

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____
12. Place of registration: _____
13. Registrar's name: _____
14. Registrar's title: _____
15. Registrar's address: _____
16. Registrar's telephone: _____
17. Registrar's fax: _____
18. Registrar's e-mail: _____
19. Registrar's website: _____
20. Registrar's office: _____
21. Registrar's hours: _____
22. Registrar's fees: _____
23. Registrar's contact information: _____
24. Registrar's signature: _____
25. Registrar's title: _____
26. Registrar's address: _____
27. Registrar's telephone: _____
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36. Registrar's title: _____
37. Registrar's address: _____
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51. Registrar's e-mail: _____
52. Registrar's website: _____
53. Registrar's office: _____
54. Registrar's hours: _____
55. Registrar's fees: _____
56. Registrar's contact information: _____
57. Registrar's signature: _____
58. Registrar's title: _____
59. Registrar's address: _____
60. Registrar's telephone: _____
61. Registrar's fax: _____
62. Registrar's e-mail: _____
63. Registrar's website: _____
64. Registrar's office: _____
65. Registrar's hours: _____
66. Registrar's fees: _____
67. Registrar's contact information: _____
68. Registrar's signature: _____
69. Registrar's title: _____
70. Registrar's address: _____
71. Registrar's telephone: _____
72. Registrar's fax: _____
73. Registrar's e-mail: _____
74. Registrar's website: _____
75. Registrar's office: _____
76. Registrar's hours: _____
77. Registrar's fees: _____
78. Registrar's contact information: _____
79. Registrar's signature: _____
80. Registrar's title: _____
81. Registrar's address: _____
82. Registrar's telephone: _____
83. Registrar's fax: _____
84. Registrar's e-mail: _____
85. Registrar's website: _____
86. Registrar's office: _____
87. Registrar's hours: _____
88. Registrar's fees: _____
89. Registrar's contact information: _____
90. Registrar's signature: _____
91. Registrar's title: _____
92. Registrar's address: _____
93. Registrar's telephone: _____
94. Registrar's fax: _____
95. Registrar's e-mail: _____
96. Registrar's website: _____
97. Registrar's office: _____
98. Registrar's hours: _____
99. Registrar's fees: _____
100. Registrar's contact information: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5346

CERTIFICATE OF DEATH

05310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>308 4th Ave. S.W.</u>				d. STREET ADDRESS <u>1 #308 - 4th Ave. S.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis Sheridan EATON</u>				4. DATE OF DEATH Month Day Year <u>5 23 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Jan. 1896</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Lamoine, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Eaton</u>				14. MOTHER'S MAIDEN NAME <u>Ethel (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>217 07 2238</u>		INFORMANT <u>Mrs. Hildegarde A. Eaton</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>50</u> , to <u>March</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>60</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. B. Macdonald M.D.</u>				ADDRESS (Street, city or town, state) <u>804 Ocean Hwy S.W. 5-2360</u>			
PHYSICIAN'S NAME (Type) <u>C. B. Macdonald M.D.</u>				DATE SIGNED <u>March 23 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>26th May 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Longleton</u>				24a. REC'D BY REGISTRAR <u>Glen Burnie, Maryland</u> DATE <u>MAY 25 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

100-100000

CERTIFICATE OF DEATH

2345

1

5347

CERTIFICATE OF DEATH

05311

Reg. Dist. No.

27

1. PLACE OF DEATH a. COUNTY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY N/A A.A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N/A Severn		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First NOT NAMED Middle EVANS Last EVANS			4. DATE OF DEATH Month May Day 18 Year 1960		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N/A DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 May 60		9. AGE (In years last birthday) yrs. 10 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Joseph Evans		
14. MOTHER'S MAIDEN NAME Idabelle Brown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		
16. SOCIAL SECURITY NO. N/A			17. INFORMANT (Mother) Mrs Idabelle Evans Box 187 Severn, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 17 May , 19 60 , to 18 May , 19 60 , that I lost the deceased on 17 May , 19 60 , and that death occurred at 3:50 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Roger C. Moyer		ADDRESS (Street, city or town, state) USA Ft Geo G Meade, Md DATE SIGNED 18 May 60			
PHYSICIAN'S NAME (Type) ROGER C. MOYER, Capt., M.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Barth R. Law		ADDRESS 802 Madison Avenue		24a. REC'D BY REGISTRAR MAY 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

Page 4
The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Now 4/60 2050241XV0

31. TROUBLE-SPOTS: 40 TON PRESSURE DOME VESSEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton			c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore and Pine Avenues				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rev. Emanuel T. Finck				4. DATE OF DEATH Month Day Year May the 30th. 1960 19			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/93	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		11. BIRTHPLACE (State or foreign country) Shelby, Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Theodore Finck				14. MOTHER'S MAIDEN NAME Helen Bush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 2-2-36-9166		17. INFORMANT Address Mrs. Rudolph Meyer (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.0 DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles S. Petty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/31/60	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2 June 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie MD	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Sington				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUN 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

5333

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A-A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A-A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN TB <u>7 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 Avondale Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Lee Paul Fitzsimmons</u>		4. DATE OF DEATH <u>5-1-60</u> 19	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26, 1919</u>
9. AGE (In years last birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James F. Fitzsimmons</u>		14. MOTHER'S MAIDEN NAME <u>Edith V. Beckman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Wife</u>	
17. INFORMANT <u>Mrs Katherine S. Fitzsimmons</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
153.8 DUE TO <u>Generalized carcinomatosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ce of bowel</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> to <u>1960</u> 19 <u>60</u> , that I last saw the deceased alive on <u>5-1-60</u> , 19 <u>60</u> , and that death occurred at <u>1:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>5-1-60</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cmty</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Fun. Dir. 4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 3 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2303

1910

The State of Maryland

NAME OF DECEASED

JOHN W. BROWN

Age 65

Sex Male

Color of Skin White

Height 5 ft 10 in

Weight 175 lbs

Married

Place of Birth

Occupation

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Time of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5348
CERTIFICATE OF DEATH

05314

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 5mo. 1 year 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-22 d. STREET ADDRESS 419 Maple Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephen First Middle Last Floyd		4. DATE OF DEATH Month Day Year 5 16 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1877 9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Floyd		14. MOTHER'S MAIDEN NAME Peggy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 214-20-6220	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO Syphilitic Cardiovascular Disease with Central Nervous System Syphilis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 12/1 1958 to 5/16 1960 , that (I) (we) last saw the deceased alive on 5/16 1960 , and that death occurred at 11:20 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE 5/17/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 21, 1960	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson, Inc. 916 Penna. Ave.		25a. REC'D BY REGISTRAR DATE MAY 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1531

OFFICE OF THE ATTORNEY GENERAL

1532



RECEIVED
JAN 11 1961
DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

MEMORANDUM
TO: THE ATTORNEY GENERAL
FROM: [illegible]
SUBJECT: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05315

5349

Items 8, 14 Film 263 5-23-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 10 years 11mo. 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 802 N. Carrollton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Martha Green		4. DATE OF DEATH Month Day Year 5 9 19 60					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1872 ? ?	
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Jones		14. MOTHER'S MAIDEN NAME Amy (Last name unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. 151X		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/22 to 5/9 , 19 60 , that (I) (we) last saw the deceased alive on 5/9 , 19 60 , and that death occurred at 12:33 M, from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 5/10/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/14/60		23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Mem. Park		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Palmer Funeral Home		ADDRESS 412 14th St N.E. Wash, D.C.		25a. REC'D BY REGISTRAR DATE MAY 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kneel	

05315*

CENTRAL AVENUE OF DEATH

5343

Marion

Marion

Marion

10 years
11. 2 days

Marion

101 E. Harrison Avenue

Marion State Hospital

Marion

Marion

1972

x

Marion

Marion

1972

Marion

Marion

Marion

Marion

Marion

Marion

Marion

Marion

60

1972

1972

1972

60

1972

1972

Marion State Hospital, Marion

Marion State Hospital, Marion

Marion

Marion

Marion

1972

1972

1972

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MEDICAL CERTIFICATION

5154

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5351

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05318

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>INDIANA</u> b. COUNTY <u>LARKE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>5 WKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>713 Cotter Rd</u>		d. STREET ADDRESS <u>12531-36th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Hugo</u> Middle <u>Wilhelm</u> Last <u>Holm</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Greens Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilhelm Holm</u>		14. MOTHER'S MAIDEN NAME <u>Pauline S. Skoglund</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>344-03-9594</u>	
17. INFORMANT <u>W. T. Holm</u>		Address <u>713 Cotter Rd Glen Burnie Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>Cerebro-vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>-</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> 19 <u>60</u> to <u>5/13</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> 19 <u>60</u> , and that death occurred at <u>11</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>R. W. Prichard</u>		22b. DATE SIGNED <u>5/13/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD</u>		22d. ADDRESS <u>715 Cotter Rd Glen Burnie Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 16 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GRACELAND Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kinkley</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>MAY 16 '60</u>	

MEDICAL CERTIFICATION

05318

CENTRAL CRUATH

5331

1

5352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) of STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>John E. Hopkins</i>		4. DATE OF DEATH Month <i>May</i> Day <i>16</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 11, 1894</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>Merchant & partner</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>South River</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James T. Hopkins</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hunt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>218-36-8822</i>	
17. INFORMANT <i>Louise Woodfield Galesville, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive cardiovascular disease</i> DUE TO <i>and diabetes mellitus</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/17/60</i> , 19 <i>60</i> , to <i>5/16/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/15/60</i> , 19 <i>60</i> , and that death occurred at <i>4:05</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Willard F. Smith</i>		DATE SIGNED <i>5/20/60</i>	
PHYSICIAN'S NAME (Type) <i>Willard F. Smith</i>		ADDRESS <i>SHADY SIDE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/18/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Quaker</i>	22d. LOCATION (City, town, or county) (State) <i>Galesville, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Q. Harduty</i>		ADDRESS <i>Galesville</i>	
24a. REC'D BY REGISTRAR <i>May 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneass</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

5308

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05320

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. #4, Box #41				d. STREET ADDRESS Rt. #4, Box #41			
3. NAME OF DECEASED (Type or print) CHARLES				4. DATE OF DEATH Month May Day 23 Year 1960			
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-14-1891	
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Emma Hunt Jones M.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent pericarditis 432X CHICK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R S Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 5/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-27-60		22c. NAME OF CEMETERY OR CREMATORY Broadneck	
				22d. LOCATION (City, town, or country) (State) St. Margarets			
23. FUNERAL DIRECTOR William Reesett				ADDRESS Anner, Md		24a. REC'D BY REGISTRAR MAY 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kane			

00333

00333

00333



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[Faint, illegible handwritten text, possibly a signature or address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5353 CERTIFICATE OF DEATH

05321

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 726 Harford Avenue	
3. NAME OF DECEASED (Type or print) First Sarah Middle Mae Last Hurt		4. DATE OF DEATH Month 5 Day 1 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1900? 59?
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mitchell Bethay		14. MOTHER'S MAIDEN NAME Rachel Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Hemiplegia DUE TO (c) Syphilitic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 8 p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/22 1955 to 5/1 1960 , that (I) (we) last saw the deceased alive on 5/1 1960 , and that death occurred at 6:20 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman		22b. DATE SIGNED 5/2/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City, town, or county) (State) A.A. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis		25a. REC'D BY REGISTRAR 10 60	
ADDRESS 1639 N. Broadway Balt., Md.		25b. REGISTRAR'S SIGNATURE Charles S. Knaus	

03331

CERTIFICATE OF DEATH

2383



Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to the quality of the scan.

5354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood Md.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Sadie</i> First <i>Jackson</i> Middle <i>G</i> Last				4. DATE OF DEATH Month <i>5</i> Day <i>31</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-25-1900</i>	
9. AGE (In years last birthday) <i>60</i> yrs.		10. IF UNDER 1 YEAR Months <i>60</i>		11. IF UNDER 24 HRS. Days <i>60</i> Hours <i>60</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>			
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John E. Hall</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Hall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Lottie Sharp Harwood Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Varicella heart with</i> <i>170X</i> DUE TO <i>Spread to other organs</i> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <i>11 mos</i> DUE TO (c) <i>11 mos</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>5-14-60</i> to <i>5-31-60</i> , that I last saw the deceased alive on <i>5-14-60</i> , and that death occurred at <i>5:30</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>G. J. Allen</i>				ADDRESS (Street, city or town, state) <i>62 Cochran St</i> DATE SIGNED <i>6-1-60</i>			
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>6.3-1960</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Adams</i>				22d. LOCATION (City, town, or county) (State) <i>Harwood Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>				24a. REC'D BY REGISTRAR <i>Anna</i> DATE <i>JUN 6 '60</i>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i>			

5555

MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

5555



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5355 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u> c. LENGTH OF STAY IN 1b <u>12 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Skywater Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u> d. STREET ADDRESS <u>Skywater Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Adeline</u> Middle <u>O.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>31st</u> Day <u>May</u> Year <u>19 60</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Aug. 1909</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Portland, Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Dickey</u>			14. MOTHER'S MAIDEN NAME <u>Lela Payson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>607 Evergreen Rd. Payson O. Johnson West Severna Park Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute ethylism and acute barbiturate</u> DUE TO <u>intoxication.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>5-10 min.</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/1/60</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2 June 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, R.F.D., Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Ellen Bannie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 6 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5309

CERTIFICATE OF DEATH

05324
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 22 West St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louise Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month May Day 24 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR: Months 9 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRESS		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Gott		14. MOTHER'S MAIDEN NAME Minerva Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-12-8006	
17. INFORMANT MINERVA V. Taylor-22-WASH. ST.		Address ANNA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with Metastases DUE TO to Pancreas, liver, regional lymph nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and lungs. Ascites with fluid contents DUE TO (c) and lungs. Ascites with fluid contents		INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 19 60 to May 24, 19 60 , that I last saw the deceased alive on May 24, 1960 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Richardson		ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED 5/25/60	
PHYSICIAN'S NAME (Type) R. L. Richardson		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-29-60	
22c. NAME OF CEMETERY OR CREMATORY PINE LAWN		22d. LOCATION (City, town, or county) (State) ANNAPOLIS - MD.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks III		ADDRESS ANNAPOLIS - MD.	
24a. REC'D BY REGISTRAR DATE JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

5356

CERTIFICATE OF DEATH

05325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.				c. LENGTH OF STAY IN 1b 2 yr. 7 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Children's Center				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vaughn Middle Eugene Last Johnson				4. DATE OF DEATH Month May Day 22 Year 1960			
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1952	
9. AGE (In years last birthday) 6 yrs.		10. UNDER 1 YEAR Months 6 Days 19 Hours 60		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Charles Wade Johnson				14. MOTHER'S MAIDEN NAME Jean Elizabeth Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Address Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 352X IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Spastic Quadriplegia DUE TO (c) Mental Retardation							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 1, 1957 , to May 22, 1960 , that I last saw the deceased alive on May 22, 1960 , and that death occurred at 10:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Boyland M.D.				ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. 5/23/60 DATE SIGNED			
PHYSICIAN'S NAME (Type) James E. Boyland, M.D.				Children's Center, Laurel, Md. 5/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1960		22c. NAME OF CEMETERY OR CREMATORY District Training School		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. [Signature] ADDRESS D. T. S. Laurel, Md.				24a. REC'D BY REGISTRAR DATE MAY 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5335

CERTIFICATE OF DEATH

5335

100-111111-111111

Form with multiple lines for text entry, including fields for name, date, and other details. The text is faint and mostly illegible.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 18 Film 262 5-13-60 am

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05326
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General</u>				d. STREET ADDRESS <u>1 Rt 8 Box 28</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>M.</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>5</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct 28, 1924</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ship building</u>		11. BIRTHPLACE (State or foreign country) <u>Fort Dodge, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl M. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Silvia May Herrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>Mrs Gladys Moore-Sister-445 Grindall St.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis with complete occlusion of the left anterior descending coronary artery</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>Pulmonary congestion and edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Wm. Lovitt</u> M.D. EXAMINER'S NAME (Type) <u>Dr Lovitt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>				22b. DATE THEREOF <u>May 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>to & in Boone, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAY 10 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5357

CERTIFICATE OF DEATH

05327

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2425 Harlem Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Manson			4. DATE OF DEATH Month 5 Day 30 Year 1960				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884		9. AGE (In years last birthday) 76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Unknown				
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary Anemia DUE TO (b) Gastro-Intestinal Hemorrhage DUE TO (c) Gastric Ulcer, Peptic CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Cerebral Hemorrhage							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----		20g. (County) -----		20h. (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 5/20 1960 to 5/30 1960 , that (I) (we) last saw the deceased alive on 5/30 1960 , and that death occurred at 4:20 P. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Hildegard Heard Reissman</i>				22b. DATE SIGNED 5/31/60			
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn			
23d. LOCATION (City, town, or county) Baltimore		23e. (State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE William M. A. Jackson F.H. Inc.				25a. REC'D BY REGISTRAR DATE JUN 2 '60			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krasa</i>							

916 PENNA AVE.

02352

CERTIFICATE OF DEATH

02352



State of Maryland
County of Baltimore
City of Baltimore
I, the undersigned, being a duly qualified physician, do hereby certify that on the 10th day of June, 1900, at the City of Baltimore, Maryland, died
John J. Jones, aged 35 years, of the County of Baltimore, State of Maryland, who was born on the 10th day of June, 1865, at the City of Baltimore, Maryland, and was the husband of Mary J. Jones, nee Smith, of the same place, and was the father of the following named children:
Mary J. Jones, born June 10, 1895
John J. Jones, born June 10, 1897
Mary J. Jones, born June 10, 1899

Witness my hand and the seal of my office this 10th day of June, 1900.
J. J. Jones, M.D.
Physician



Subscribed and sworn to before me this 10th day of June, 1900.
J. J. Jones, M.D.
Physician

Witness my hand and the seal of my office this 10th day of June, 1900.
J. J. Jones, M.D.
Physician

5358

CERTIFICATE OF DEATH

05329
Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. LENGTH OF STAY IN 1b 2 hrs 15 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last INFANT MALE KATAGIRI		4. DATE OF DEATH Month Day Year May 13 1960	
5. SEX Male	6. COLOR OR RACE Mong.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 May 1960
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days 2 15	11. IF UNDER 24 HRS. Hours Min. 2 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Taro Katagiri		14. MOTHER'S MAIDEN NAME Sonoko Suzuki	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT (Mother) Sonoko Katagiri - 1924-C Reece Rd. Ft GGM, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 May 1960 to 13 May 1960 that I last saw the deceased alive on 13 May 1960 , and that death occurred at 1:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 13 May 60			
ACTUAL SIGNATURE Carl A. Fischer		M.D.	
PHYSICIAN'S NAME (Type) CARL A. FISCHER, LT COL, MC		US Army Hospital, Fort George G. Meade, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 13 May 1960	22c. NAME OF CEMETERY OR CREMATORY Laboratory, U.S. Army Hospital, Ft Geo G. Meade, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE B. M. Ellis		24a. REC'D BY REGISTRAR DATE MAY 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

0238

5311

CERTIFICATE OF DEATH

05328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>305 Chesapeake Ave.,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>R</u> Last <u>KING</u>				4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19th 1909</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William E. Lowman</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Mumford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>George T. King</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of esophagus</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Mon</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-30-1960</u> to <u>May 26, 1960</u> , that I last saw the deceased alive on <u>May 26, 1960</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				DATE SIGNED <u>5/27/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 30 - 1960</u>		<u>St. Ann's Cemetery</u>		<u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sr.</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5359

CERTIFICATE OF DEATH

Reg. Dist. No. **05330**

1. PLACE OF DEATH a. COUNTY ANNe Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 519 Matthew Ave.				d. STREET ADDRESS 519 Matthew Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle L. Last Kosack				4. DATE OF DEATH Month 5 Day 18 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/97		9. AGE (In years lost by day) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lwarence				14. MOTHER'S MAIDEN NAME Theresa Weber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW # I		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion & hypertensive cardiac vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) partial st. thrombolyia DUE TO (c) partial st. thrombolyia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10 , 19 54 to 5/17 , 19 60 , that I last saw the deceased alive on 5/17 , 19 60 , and that death occurred at 4a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip W. Keister, M.D.		ADDRESS (Street, city or town, state) 302 PATAPSCO ave		DATE SIGNED 5/19/60			
PHYSICIAN'S NAME (Type) KEISTER, PHILIP W.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes				ADDRESS 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE MAY 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DENY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05331

5360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. LENGTH OF STAY in 1b <u>Few minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape St. Claire, P.O. Annapolis</u> X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Annapolis Rd. 1000 ft. N. of Ritchie</u>				d. STREET ADDRESS <u>RFD Rt # 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Howard</u> Last <u>Lawson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 13, 1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assessor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Howard Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Robertson Fountain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 036165</u>		17. INFORMANT <u>Family</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide by Cyanide Poisoning</u> <u>971.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost, DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Place Cyanide in whiskey and drank</u>			
20c. TIME OF INJURY Hour <u>9:10</u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>5/ 13/1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Arnold</u> <u>AA</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustav M. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustav Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco</u> ADDRESS <u>Severna Park Funeral Home of Robert S. Barranco</u>				24a. REC'D BY REGISTRAR <u>MAY 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5312

CERTIFICATE OF DEATH

05332

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>320</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>320 Box 30, RFD 4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> M Middle <u>LIND</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1903</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Morris Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Ida M. Benner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Conrad Lind, Box 320 RFD 4, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion, recent</u> DUE TO <u>ant. myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia left lower lobe</u> DUE TO <u>adenoma of adrenal gland</u> (c) <u>phlebotomy, infection, embolism</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>phlebotomy, infection, embolism</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-8</u> , 19 <u>59</u> , to <u>5-9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-9</u> , 19 <u>60</u> , and that death occurred at <u>11:30 A.</u> M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Edith Rodler</u>				M.D. <u>45 Franklin St - Annapolis Md.</u>			
PHYSICIAN'S NAME (Type) <u>EDITH RODLER MD</u>				<u>FRANKLIN ST. ANNAPOLIS, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Geln Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ullrich Funeral Home 4210 Belair Road.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 13 60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. faubert - Dep. Med-Examiner Notified on 5/20/60
Approval of issue of Cert. given 5/20/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5361

05333

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severna Park</u>	
c. LENGTH OF STAY IN 1b <u>3 mos. App.</u>		d. STREET ADDRESS <u>3 Cedar Pt. Road, Linstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stann's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lula (Lorissa) J. Lint</u>	First <u>Lula</u> Middle <u>(Lorissa)</u> Last <u>J. Lint</u>	4. DATE OF DEATH <u>5/19/1960</u>	Month <u>5</u> Day <u>19</u> Year <u>1960</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Hald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Kathryn Donovan</u>		Address <u>113 Boone Trail, Severna Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Convulsive Seizure</u> DUE TO <u>780.2</u> (b) <u>Cholera undetected</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Right Hip.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/15/1960</u> to <u>5/19/1960</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>MD.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>JOSEPH LIPSKEY</u>		22b. DATE SIGNED <u>5/20/60</u>	
22c. PHYSICIAN'S NAME (Print) <u>JOSEPH LIPSKEY</u>		22d. ADDRESS <u>DENTON, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>23rd May 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Dingleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie</u> DATE <u>MAY 23 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

02833

CERTIFICATE OF DEATH

5381



DR. JOSEPH LIPSKY
Germantown, Maryland

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 5362 CERTIFICATE OF DEATH

05334

1. PLACE OF DEATH a. COUNTY MARYLAND Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 mo. 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) Raymond				4. DATE OF DEATH Month 5 Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1883	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Long				14. MOTHER'S MAIDEN NAME Anna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial - Cardiac Arrest 33.4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C.B.S. assoc. w. Coronary & Generalized arteriosclerosis DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 ----- p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				(County) -----		(State) -----	
21. I certify that (I) (this hospital) attended the deceased from 4/2 1957 to 5/20 1960 , that (I) (we) last saw the deceased alive on 5/20 1960 , and that death occurred at 8:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 5/20/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-60		23c. NAME OF CEMETERY OR CREMATORY Trindley chapel		23d. LOCATION (City, town, or county) (State) Pocomoke Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Reese				ADDRESS Annapolis, Md		25a. REC'D BY REGISTRAR DATE JUN 2 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kinnel			

05336

CERTIFICATE OF DEATH

2532

10

1

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]

1
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5363

05335

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 32 years 10 mo. 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Magruder Last Magruder				4. DATE OF DEATH Month May Day 12 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884	
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Emery Duffin				14. MOTHER'S MAIDEN NAME Sarah Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Cardis - DUE TO (c) vascular disease & Chronic Brain Syndrome							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While ----- while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 7/11 1960 to 5/12 1960 , that (I) (we) last saw the deceased alive on 5/12 1960 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				22b. DATE 5/12/60		22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland				22e. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 16, 1960		23b. DATE THEREOF May 16, 1960		23c. NAME OF CEMETERY OR CREMATORY Washington Cem.		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE William L. Noten		24b. ADDRESS 2718-124th St Wash DC		25a. REC'D BY REGISTRAR DATE MAY 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

582

x

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2d, Film G262 5/16/60 iwk

5364

CERTIFICATE OF DEATH

05336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kirkley Rd</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kirkley Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Annapolis, Md.</u>			
3. NAME OF DECEASED (Type or print) <u>Anne Mary Marshall</u>				4. DATE OF DEATH <u>5-11-60</u> 19 <u>60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1887</u>	9. AGE (In years lost birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>John V. Farris</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son, Richard Marshall</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> Generalized (c) <u>Generalized</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>5-6-60</u> , 19 <u>19</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>5-11-60</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				DATE <u>5-11-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 14-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Margarets Cent</u>		22d. LOCATION (City, town, or county) (State) <u>St Margarets Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sun Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanes</u>	

CERTIFICATE OF DEATH

1936

NAME OF DECEASED _____	
SEX _____	
AGE _____	
DATE OF BIRTH _____	
PLACE OF BIRTH _____	
OCCUPATION _____	
CAUSE OF DEATH _____	
PLACE OF DEATH _____	
TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____	
DATE _____	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5365

CERTIFICATE OF DEATH

05337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broadneck</u>		d. STREET ADDRESS <u>R.F.D. 2</u>	
3. NAME OF DECEASED (Type or print) <u>Wesley Edward Miller</u>		4. DATE OF DEATH <u>MAY 22 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 14-1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <u>Contractor - Self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Miller</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-14-4005</u>	
17. INFORMANT <u>MARY E. MILLER - Arnold - Md. Rt. 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-22-60</u> to <u>5-22-60</u> , that I last saw the deceased alive on <u>5-22-60</u> , 19 <u>60</u> , and that death occurred at <u>1030</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 E. Chestnut</u> DATE SIGNED <u>5-24-60</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-26-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Arnold Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks III</u> ADDRESS <u>ANNAPOLIS - Md</u>		24a. REC'D BY REGISTRAR <u>June 1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Christina L. Hines</u>	

1256

56620

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>Bay Ridge Annapolis Md</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General</i>				d. STREET ADDRESS <i>110 Bancroft Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Catherine Alice Montgomery</i>				4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-9-1957</i>	9. AGE (In years last birthday) <i>3</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>H. Saylor Montgomery</i>				14. MOTHER'S MAIDEN NAME <i>Hilda Farr</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>H. Saylor Montgomery</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8 Drowning</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Child fell from pier into water</i>					
20c. TIME OF INJURY Month, Day, Year Hour <i>4</i> a. m. <i>5/13/60</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>near home</i>	20f. (City or town) <i>Bay Ridge</i>	(County) <i>aa</i>	(State) <i>Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>MAY 13/60</i>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 15-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>		ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>MAY 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5366

CERTIFICATE OF DEATH

05340

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>ELEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachel Moore</u>		4. DATE OF DEATH <u>5-21-1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Augustus Moore</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Daley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Leo Boston - DPW. - a.a. lv.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <u>443 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prolapse Rectum</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour a.m. — p.m. — 19</u>	20d. INJURY OCCURRED <u>While</u> <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>5-4-</u> 19 <u>60</u> to <u>5-21-</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>5-7-</u> 19 <u>60</u> and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James M. Pair</u>		22b. DATE SIGNED <u>5-21-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>James M. Pair - M.D.</u>		22d. ADDRESS <u>490 N. Carrollton Ave. Balt 23</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/25/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Saints Rest Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Harmans Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs Kate R Williams</u>		25a. REC'D BY REGISTRAR <u>Schroeder St.</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>MAY 25 '60</u>	



090

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1

2

(M)

2388

(1)

Hypertensive Cardiovascular Disease

— Hypertension —

Isolated Systolic

Myocardial Infarction

1971-1972

The New York

Presbyterian Hospital

First Avenue

Manhattan

10021

James H. McGraw
James H. McGraw
James H. McGraw

James H. McGraw

James H. McGraw

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5367

CERTIFICATE OF DEATH

05341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENOCK</u>		c. LENGTH OF STAY IN 1b <u>67 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X Greenock</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD FRANK MORELAND</u>		4. DATE OF DEATH Month Day Year <u>May 8 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 31 1892</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>	
11. BIRTHPLACE (State or foreign country) <u>Greenock</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William E. Moreland</u>		14. MOTHER'S MAIDEN NAME <u>Muriel E. Moreland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>ORLANDO MORELAND Edgewater, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma prostate</u> DUE TO <u>1777X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma prostate</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>58</u> , to <u>May 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>60</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Edgewater, MD</u> DATE SIGNED <u>5-10-60</u> ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D. <u>L. H. Wilson</u> PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Harduty</u> ADDRESS <u>Edgewater, MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

528C

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5368 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtis Bay</u>			c. LENGTH OF STAY IN 1b <u>8 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 13</u> 3V01.4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In the Infirmary of Coast Guard Yard</u>				d. STREET ADDRESS <u>3415 Parklawn Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur Mc Nally</u>				4. DATE OF DEATH <u>MAY 4th. 1960</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/26/1900</u>			
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>19</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>John McNally</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Feehly</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>In Marine Corps 9 years</u>				16. SOCIAL SECURITY NO. <u>Mrs. Mary Mc Nally (wife)</u>					
17. INFORMANT <u>Mrs. Mary Mc Nally (wife)</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>5/4/60</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>				ADDRESS <u>4210 Belair Road</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

MEDICAL CERTIFICATION

TO THE CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please enclose a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the City Medical Examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5314

05342
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Riva			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS South River Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carl J Ostlund				4. DATE OF DEATH Month Day Year May 23 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl J. Ostlund				14. MOTHER'S MAIDEN NAME Sofia Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Miss Eline Ostlund-Sister- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Multiple Sclerosis DUE TO (b) Interosseal sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) E. L. Woodward				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF May 25, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or county) Washington, D.C.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS ANNAPOLIS, MD.		24a. REC'D BY REGISTRAR DATE MAY 27 '60	
24b. REGISTRAR'S SIGNATURE C. L. S. Krawt							

02820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
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73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5369

CERTIFICATE OF DEATH

05343

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Linthicum				c. LENGTH OF STAY IN 1b 9 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 30 Old Annapolis Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle OWENS Last				4. DATE OF DEATH Month May Day 12 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1869	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Ret.				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) New York State	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Michael Owens				14. MOTHER'S MAIDEN NAME Mary Bridget Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. James Owens Jr.				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Chronic Myocardial Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1955 to May 13, 1960 that (I) (we) last saw the deceased alive on May 14, 1960 , and that death occurred at 3:30 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Louis J. Glass				22b. DATE SIGNED May 13, 1960			
22c. PHYSICIAN'S NAME (Type) Louis J. Glass				22d. ADDRESS 320 Patapsco Ave. Balto. 25, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 16, 1960			
23c. NAME OF CEMETERY OR CREMATORY St. Gertrude's Cemetery				23d. LOCATION (City, town, or county) (State) Woodbridge, New Jersey			
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gomer				25a. REC'D BY REGISTRAR DNA MAY 18 '60			
ADDRESS 4001 Ritchie Hwy. Bal to 25				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

03346A

CERTIFICATE OF DEATH

2368



Death certificate
Certificate of death

5315

CERTIFICATE OF DEATH

05344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 W. Washington Street</u>				e. STREET ADDRESS <u>100 W. Washington</u>			
3. NAME OF DECEASED (Type or print) <u>Katie</u> First <u>Parker</u> Middle <u>Parker</u> Last				4. DATE OF DEATH <u>5</u> Month <u>17</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-24-1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McSorrows Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>James Parker</u> Address <u>100 W. Wash. St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4/1/60-5/17/60</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>60</u> , to <u>May 17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 17</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Dr. Theodore H. Johnson, Jr.</u> M.D. <u>37 Calvert Street</u> <u>May 18, 1960</u> PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u> <u>Annapolis, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-20-60</u>		<u>Pine Lawn</u>		<u>Rest Gate Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05345

5370

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Millersville (RFD) E/vator</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Juniper Hole Road, E/vator</u>		d. STREET ADDRESS <u>Box 302 - Juniper Hole Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Petett</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28th Apr. / 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Local #48</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Petett</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Mabel L. Petett</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA COLON</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 2</u> , 19 <u>60</u> , to <u>MAY 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAY 21</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.R. MacDonald MD</u> M.D.		ADDRESS (Street, city or town, state) <u>204 Glen Burnie Hwy</u> DATE SIGNED <u>5-25-60</u>	
PHYSICIAN'S NAME (Type) <u>C.R. MacDonald, M.D.</u>		<u>Glen Burnie MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>25th May 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Sumpster</u> ADDRESS <u>Glen Burnie, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u>	

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
5371 **CERTIFICATE OF DEATH** **05346**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 13 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			d. STREET ADDRESS Unknown		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Walter Middle Polk Last Polk			4. DATE OF DEATH Month 5 Day 17 Year 1960		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1896		9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942	17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour ----- 19 p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that (I) (this hospital) attended the deceased from 5/4/1960 to 5/17/1960 , that (I) (we) last saw the deceased alive on 5/17/1960 , and that death occurred at 8 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Hildegard Heard Reissman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/17/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 6/2/60	23c. NAME OF CEMETERY OR CREMATORY University of Md.		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Leese		ADDRESS 108 W. Wash. St. Annapolis, Md.		25a. REC'D BY REGISTRAR JUN 6 '60	25b. REGISTRAR'S SIGNATURE Arthur S. House

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1502

1993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5316

CERTIFICATE OF DEATH

05347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDGAR Last PORTER		4. DATE OF DEATH Month May Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30 1913
9. AGE (In years lost birthday) yrs. 47		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIR CONDITION		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES C PORTER		14. MOTHER'S MAIDEN NAME STELLA MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT ANNA M. PORTER		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/3 , 19 60 , to 5/4 , 19 60 , that I last saw the deceased alive on 5/3 , 19 60 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 5/4/60			
ACTUAL SIGNATURE Richard N. Peeler		M.D. 121 Cathedral St.,	
PHYSICIAN'S NAME (Type) Richard N. PEELER		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6-1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Sayla Sons		ADDRESS Annapolis Md	
24a. REC'D BY REGISTRAR MAY 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05348
 5372 Item 3 Film G264 6-3-60 et
 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 4 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1009 Phillip Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Joseph Last Ptacek, Sr.				4. DATE OF DEATH Month MAY Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1916	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker				10b. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Frank Ptacek				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. May 45- Jul 46 213-01-5139			
17. INFORMANT Mrs. Grace Ptacek (wife)				Address Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA, STOMACH DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 3 MOS.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from FEB. , 1960, to MAY 25 , 1960, that I last saw the deceased alive on MAY 24 , 1960, and that death occurred at 11:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5-25-60 ACTUAL SIGNATURE Leon C. Perry, M.D. PHYSICIAN'S NAME (Type) Leon C. Perry, M.D. Glen Burnie, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF May 28, 1960							
22c. NAME OF CEMETERY OR CREMATORY Glen Haven							
22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley 421 Crain Hgwy. SE Glen Burnie, Md.							
24a. REC'D BY REGISTRAR DATE MAY 31 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

5373

CERTIFICATE OF DEATH

1934

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *May 15, 1889*

5. Place of birth: *New York, U.S.A.*

6. Date of death: *Nov 27, 1934*

7. Place of death: *New York, U.S.A.*

8. Cause of death: *Heart Disease*

9. Signature of physician: *John J. Smith*

10. Signature of registrar: *John J. Smith*

11. Date of registration: *Nov 27, 1934*

12. Place of registration: *New York, U.S.A.*

5317

CERTIFICATE OF DEATH

05349
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>ANNAPOLIS</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>ANNAPOLIS</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNAPOLIS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHURCHTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ANNAPOLIS GEN HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Winifred A Randall</i>		4. DATE OF DEATH <i>May 14 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 28. 1927</i>
9. AGE (In years lost birthday) <i>33</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>WASHINGTON DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRANCIS J DORSEY</i>		14. MOTHER'S MAIDEN NAME <i>MARY E LACEY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>Francis J Dorsey Churchton Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hydronephrosis and broncho pneumonia</i> <i>038X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Granuloma inguinale</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>one month</i> <i>6 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1</i> , 19 <i>60</i> , to <i>May 14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>May 14</i> , 19 <i>60</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>SHADY SIDE, MD.</i> DATE SIGNED <i>5/15/60</i>			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		PHYSICIAN'S NAME (Type) <i>WILLARD F SMITH, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>5-18-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Our Lady of Sorrows</i>		22d. LOCATION (City, town, or county) (State) <i>Owensville Md</i>	
23. BURIAL DIRECTOR'S SIGNATURE <i>J. Lee Jones</i> ADDRESS <i>300-44th St & Paul St</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3815

CERTIFICATE OF DEATH

U.S. DEPT. OF HEALTH
U.S. BUREAU OF VITAL STATISTICS
U.S. OFFICE OF VITAL STATISTICS

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1925*
5. Place of death: *Home*
6. Cause of death: *Heart disease*
7. Signature of physician: *Dr. J. Smith*
8. Signature of registrar: *John Doe*
9. Date of registration: *Jan 15 1925*
10. Place of registration: *City of New York*

05350

5318

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		10 Annapolis									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		(Dead on arrival)		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
John		R		RAWLINGS				May		20		19		60			
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		March 27, 1891		9. AGE (In years last birthday) yrs.		69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Annapolis Daily Salesman				Maryland		U.S.											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME															
Samuel F. Rawlings		Anna M. Purdy															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address											
YES		1917-1919		Agnes S. Rawlings		(2)											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.1		DUE TO		Cerebral myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH		10 min.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
Hour o. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>															
21. I certify that I attended the deceased from May 2, 1960, to May 20, 1960, that I last saw the deceased alive on May 20, 1960, and that death occurred at 10:45 A.M., from the causes and on the date stated above.																	
ACTUAL SIGNATURE		John L. Hedeman		M.D.		121 Cathedral St.,		DATE SIGNED		5/20/60							
PHYSICIAN'S NAME (Type)		John L. Hedeman		Annapolis, Maryland													
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)									
Burial		May 22, 1960		Cedar Bluff		Annapolis		MD									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
John M. Taylor Sons		Annapolis, MD		MAY 25 '60		Arthur S. Evans											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HO ~~SP~~AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5373

Item 8 Film 264 6-6-60 et

CERTIFICATE OF DEATH

05351

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore		c. LENGTH OF STAY IN lb 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Seventh Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Brooklyn Park)	
3. NAME OF DECEASED (Type or print) First Middle Last Frieda M. Rehan		4. DATE OF DEATH Month Day Year May 27, 1960 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1898/1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Emil Kunze		14. MOTHER'S MAIDEN NAME Elizabeth Kraft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Edward Rehan Jr.	
17. INFORMANT Mr. Edward Rehan Jr.		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Arteriosclerotic Cardiac Vascular Disease DUE TO 4 years (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 2/6 1956 5/27 60	
21. I certify that (I) (this hospital) attended the deceased from 2/6 19 56 to 5/27 19 60 , that (I) (we) lost saw the deceased alive on 5/26 19 60 , and that death occurred at 7AM , from the causes and on the date stated above.			
22a. SIGNATURE Benjamin Berdamm		22b. DATE May 27, 1960	
22c. PHYSICIAN'S NAME (Type) Benjamin Berdamm		22d. ADDRESS 5010A Gov. Ritchie Hwy. Balto. 25. A. A.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 30, 1960	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Taylor Ave., Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		25a. REC'D BY REGISTRAR DUN 1 '60	
ADDRESS 4001 Ritchie Hwy. (25)		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

10000

CENTRAL BANK

2013

(Date of Birth)

1000

1000

1000

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1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, telephone call, Wilson Funeral Home 7/12/60

5374

CERTIFICATE OF DEATH

05352
CAC

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patapsco Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patapsco Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>219 Bolivar AVE</u>		d. STREET ADDRESS <u>219 Bolivar AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Virginia</u> Middle <u>Reynolds</u> Last		4. DATE OF DEATH Month <u>5</u> - Day <u>13</u> - Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1874.86</u> yrs.
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sandy Scott</u>	
14. MOTHER'S MAIDEN NAME <u>Sallie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Genevieve Turner</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>March 29, 1960</u> to <u>May 13, 1960</u> , that I last saw the deceased alive on <u>May 11, 1960</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Thos J. Woolridge</u> M.D.		ADDRESS (Street, city or town, State) <u>Rt 4 Box 212 Elkridge</u> DATE SIGNED <u> </u>	
PHYSICIAN'S NAME (Type) <u>THOS J. WOOLRIDGE</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>5-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>	
22d. LOCATION (City, town, or county) (State) <u>Anne Arundle Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos O. Wilson</u> ADDRESS <u>2800 Brantley Ave</u>	
24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

2378

DATE OF DEATH

MARRIAGE

ANNE A. WOOD

RECEIVED

214 E. BALTIMORE AVE.

ALICE VIRGINIA KENNEDY

1-1-1921

WIFE OF

214 E. BALTIMORE AVE.

WIFE OF

214 E. BALTIMORE AVE.

DATE OF DEATH

1-1-1921

1-1-1921

1-1-1921

1-1-1921

1-1-1921

1-1-1921

1-1-1921

1-1-1921

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510
5375
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH
06524

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 10 years 7mo. 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 316 North Parrish Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Noretta Middle Boston Last Ringgold				4. DATE OF DEATH Month 5 Day 31 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Boston				14. MOTHER'S MAIDEN NAME Mary Bradegs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Hypostatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inanition DUE TO (c) Carcinoma of Breast with Metastases		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 2/1 1949 , to 5/31 1960 , that (I) (we) last saw the deceased alive on 5/31 1960 , and that death occurred at 1:50 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/31/60	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF June 6, 1960		23c. NAME OF CEMETERY OR CREMATORY County of Maryland		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese				25a. REC'D BY REGISTRAR -----		25b. REGISTRAR'S SIGNATURE -----	

5319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b <u>79 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 Chesapeake Ave.</u>				d. STREET ADDRESS <u>#1 D</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN THOMAS RUSSELL</u>				4. DATE OF DEATH Month Day Year <u>MAY 22 1960</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 21, 1880</u>			
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOHN HICKS RUSSELL</u>				14. MOTHER'S MAIDEN NAME <u>EMILY WHITE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>DR CARL P. RUSSELL ANNAPOLIS MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS, GENERALIZED</u> 3 yrs. 1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan 10, 1958</u> to <u>5-22-1960</u> that I last saw the deceased alive on <u>5-20-1960</u> and that death occurred at <u>12 Noon</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>James R. Martin</u>				M.D. <u>6 SHAW ST.</u>		DATE SIGNED <u>5-23-60</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				<u>ANNAPOLIS, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-25-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5320

CERTIFICATE OF DEATH

05354

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 216 Lockwood Court			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Addie F SAVAGE				4. DATE OF DEATH Month Day Year May 23 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1882	9. AGE (In years lost birthday) yrs. 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN D GADD				14. MOTHER'S MAIDEN NAME AMANDA PARKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT SELF			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 19 60 , to May 22, 19 60 , that I last saw the deceased alive on May 22, 19 60 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck				ADDRESS (Street, city or town, state) 71 Franklin St.,		DATE SIGNED 5/23/60	
PHYSICIAN'S NAME (Type) Edward S. Beck				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-25-1960		22c. NAME OF CEMETERY OR CREMATORY ST. ANNE'S CEM.		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR - SON ANNAPOLIS MD.				24a. REC'D BY REGISTRAR DATE MAY 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05355
5376 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>X</i> b. COUNTY <i>same</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i>				c. LENGTH OF STAY IN lb <i>45 yr.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>441 Hawthorne Rd.</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Jeanette</i> Middle <i>Armiger</i> Last <i>Shaper</i>				4. DATE OF DEATH Month <i>may</i> Day <i>18</i> Year <i>1960</i>					
5. SEX <i>X</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/29/74</i>			
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Prince George Co Md.</i>			
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <i>Thomas A. Armiger</i>				14. MOTHER'S MAIDEN NAME <i>Georgiana Duckett</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Lester Shaper - same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Haemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio-sclerosis + Hypertension</i> DUE TO <i>20 yr</i> (c)								INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <i>5/18/60</i> , 19 <i>58</i> , to <i>5/18/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5/18/60</i> , 19 <i>60</i> , and that death occurred at <i>6:50 P.M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Chas. L. Ball Jr</i> M.D. <i>Linthicum Md.</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>5/18/60</i>					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/21/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tiekner</i> ADDRESS <i>7 Sours - Balto.</i>				24a. REC'D BY REGISTRAR <i>17 Md</i>		24b. REGISTRAR'S SIGNATURE <i>William L. Hume</i>			

1
FOR STATE
HEALTH DEPT.
M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5377 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05356

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewater				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Woodland Beach			
3. NAME OF DECEASED (Type or print) CHESTER M. SHAFFER				4. DATE OF DEATH Month May Day 2 , Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July-17-1909 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Norris M. Shaffer				14. MOTHER'S MAIDEN NAME Beulah Bassford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service)				16. SOCIAL SECURITY NO. —			
17. INFORMANT Mrs Beulah Bassford Shaffer (2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage 331 X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 5/2/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-5-1960		22c. NAME OF CEMETERY OR CREMATORY Davidsonville Cmt	
23. FUNERAL DIRECTOR John M. Saylor Sons				24a. REC'D BY REGISTRAR May 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	
				24c. ADDRESS Annapolis Md.		24d. LOCATION (City, town, or country) (State) Davidsonville Md.	

05350

5377

FOR STATE
HEALTH DEPT
11

NAME (Printed)

Address

City

State

Signature

Signature

DATE

NAME (Printed)

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5321

CERTIFICATE OF DEATH

05357

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Shadyside			
				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First OSCAR Middle Lynn Last SIEGERT				4. DATE OF DEATH Month May Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1897	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Farmer				10b. KIND OF BUSINESS OR INDUSTRY STORE & HOME Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Wm. O. Siegert				14. MOTHER'S MAIDEN NAME Agnes Nutwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-14-2136		17. INFORMANT Address Ed E Siegert, Shadyside Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of myocardium & cardiac tamponade 429.1 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 days DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis and uremia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 8 , 1960 to May 2 , 1960, that I last saw the deceased alive on May 2 , 1960, and that death occurred on 4:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Shadyside, Md. DATE SIGNED 5/3/60 ACTUAL SIGNATURE Willard F. Smith M.D. PHYSICIAN'S NAME (Type) Willard F. Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE, THEREOF 5/6/60		22c. NAME OF CEMETERY OR CREMATORY ROSEBUD		22d. LOCATION (City, town, or county) (State) ITATESVILLE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Barbara Hurduty				ADDRESS Salisbury Md.		24a. REC'D BY REGISTRAR DATE MAY 9 '60	
				24b. REGISTRAR'S SIGNATURE C. E. G. Guss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5378

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Allen Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Grace Last Simmons				4. DATE OF DEATH Month May Day 13 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1889	
9. AGE (In years last birthday) 70		10. AGE UNDER 1 YEAR Months — Days — Hours — Min. —		11. AGE UNDER 24 HRS. Months — Days — Hours — Min. —		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) Harford County, Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Ellis				14. MOTHER'S MAIDEN NAME Alice R. White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. none			
17. INFORMANT Alice V. Foster				Address 2138 Harford Road, ZONE 18			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — INTERVAL BETWEEN ONSET AND DEATH minutes several yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4-1 , 19 58 , to May 13 , 19 60 , that I last saw the deceased alive on April 25 , 19 60 , and that death occurred at 11: P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Ellsworth Cook				DATE SIGNED 5-16-60			
PHYSICIAN'S NAME (Type) E ELLSWORTH COOK				ADDRESS (Street, city or town, state) 2431 MARYLAND AVENUE Baltimore, 18 Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 5-17-60			
22c. NAME OF CEMETERY OR CREMATORY Mt. Vernon Church Cemetery				22d. LOCATION (City, town, or county) (State) Prospect, Harford Co., Md			
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAY 17 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

1938

DEPARTMENT OF HEALTH



CERTIFICATE OF DEATH

1938

11



1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5322
CERTIFICATE OF DEATH

05359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 205 4th Ave., S.W.	
3. NAME OF DECEASED (Type or print) First Sarah Middle SIMONDS Last SIMONDS		4. DATE OF DEATH Month May Day 2 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Dulaney		14. MOTHER'S MAIDEN NAME Almedia Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no /////		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. George Simonds		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension w/ CVD DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 13, 19 60 to May 2, 19 60 , that I last saw the deceased alive on May 2, 1960 , and that death occurred at 9:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md. DATE SIGNED 5/2/60			
ACTUAL SIGNATURE Frank M. Shipley		M.D. 121 Cathedral St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) Frank M. Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5th May 1960	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kline		ADDRESS Glen Burnie, Md.	
24a. REC'D BY REGISTRAR DATE MAY 4 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

WATLAND STATE DEPARTMENT OF HEALTH - BATHINGORE, 18

1935

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male / Female]</p>	
<p>3. AGE [Age of deceased]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. OCCUPATION [Occupation]</p>	
<p>7. MARITAL STATUS [Married / Single / Widowed / Divorced]</p>		<p>8. DATE OF DEATH [Date of death]</p>	
<p>9. TIME OF DEATH [Time of death]</p>		<p>10. PLACE OF DEATH [Place of death]</p>	
<p>11. CAUSE OF DEATH [Cause of death]</p>		<p>12. MEDICAL HISTORY [Medical history]</p>	
<p>13. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>14. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>15. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>16. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>17. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>18. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>19. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>20. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>21. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>22. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>23. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>24. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>25. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>26. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>27. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>28. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>29. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>30. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>31. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>32. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>33. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>34. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>35. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>36. SIGNATURE OF WITNESS [Signature of witness]</p>	
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<p>39. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>40. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>41. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>42. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>43. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>44. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>45. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>46. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>47. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>48. SIGNATURE OF WITNESS [Signature of witness]</p>	
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<p>51. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>52. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>53. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>54. SIGNATURE OF WITNESS [Signature of witness]</p>	
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<p>57. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>58. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>59. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>60. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>61. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>62. SIGNATURE OF WITNESS [Signature of witness]</p>	
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<p>65. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>66. SIGNATURE OF WITNESS [Signature of witness]</p>	
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<p>69. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>70. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>71. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>72. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>73. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>74. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>75. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>76. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>77. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>78. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>79. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>80. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>81. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>82. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>83. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>84. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>85. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>86. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>87. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>88. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>89. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>90. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>91. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>92. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>93. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>94. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>95. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>96. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>97. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>98. SIGNATURE OF WITNESS [Signature of witness]</p>	
<p>99. SIGNATURE OF DECEASED [Signature of deceased]</p>		<p>100. SIGNATURE OF WITNESS [Signature of witness]</p>	

053640

5323

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>		d. STREET ADDRESS <u>18 Boone Trail</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eleanor</u> First <u>G.</u> Middle <u>Stack</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>60</u> 19	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 26, 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Christopher Hinrichs</u>		14. MOTHER'S MAIDEN NAME <u>Edith Edythe Peimner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-05-7072</u>	
17. INFORMANT <u>Husband</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u>a. m.</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>5-27-60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>5-23</u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R Holm</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>5-28-60</u>	
PHYSICIAN'S NAME (Type) <u>Robert R Holm</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dryd Ridge Com.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Tiekner</u> ADDRESS <u>Severna Park</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Homan</u>			

5379

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G263 5-20-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Pleasant Glen Burnie</u>				c. LENGTH OF STAY IN lb <u>6 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Near a shed, Box 209 Route 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nicholas Andrew Steinbach</u>				4. DATE OF DEATH <u>May 15th.</u> 19 <u>60</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/04</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>18</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired seaman and night watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Steinbach</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>101-10-1653</u>		17. INFORMANT <u>Mrs. Nedie Steinbach (wife)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420,1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO cause lost. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/15/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC.</u>				ADDRESS <u>715 Light St. -30</u>		24a. REC'D BY REGISTRAR <u>MAY 18 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gustave H. Faubert</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5324

CERTIFICATE OF DEATH

05364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>				d. STREET ADDRESS <u>2060 Forest Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alexander Stewart</u>				4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Bookwork</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joab Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Frances Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>W. N. T.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accidents & St. Poplegia</u> DUE TO <u>Hypertension Cerebral Vascular Disease Due to</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>1 yr.</u> <u>2 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/11</u> , 19 <u>60</u> , to <u>5/19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>60</u> , and that death occurred at <u>7:00</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>37 Lakeland Street</u>			
PHYSICIAN'S NAME (Type) <u>Dr. THEODORE H. JOHNSON</u>				DATE SIGNED <u>7/29/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chew Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u> ADDRESS <u>H. Anna Md.</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>MAY 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

1932

STATE OF NEW YORK

1932

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5380
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05362

1. PLACE OF DEATH a. COUNTY <u>Clare Anne del</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Clare Anne del</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ann Nursing Home</u>		d. STREET ADDRESS <u>11111111111111111111</u>	
3. NAME OF DECEASED (Type or print) <u>Mamie E. Stuchcomb</u>		4. DATE OF DEATH <u>5/1-1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1870</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (act)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>A. G. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Moore</u>		14. MOTHER'S MAIDEN NAME <u>Harnett Oakley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Elth L. Jenkins</u>		Address <u>Sanas #2</u>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hematuria - possibly C. 4. Bladder</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Years</u> <u>4 Years</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoporosis - chronic</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 23 1960</u> to <u>May 1- 1960</u> , that (I) (we) last saw the deceased alive on <u>4/26 1960</u> and that death occurred at <u>6:55 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Lipskey</u>		22b. ADDRESS <u>Odenton, Maryland</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>JOSEPH LIPSKEY</u>		22d. ADDRESS <u>Odenton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4th May 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Singleton</u>		25a. REC'D BY REGISTRAR <u>W. J. Singleton</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		DATE <u>MAY 4 '60</u>	

22b. DATE SIGNED 5/1-60

1888

1888

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D.181

JOHN H. LIPSEY
JOHNSON, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>Sudden</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gov. Ritchie Hwy</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Selman</u>		4. DATE OF DEATH <u>5-31-60</u> 19	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Jan. 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Drydock</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William V. Stinchcomb</u>		14. MOTHER'S MAIDEN NAME <u>Maggie (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Robert H. Stinchcomb</u>		Address <u>4200 Audrey Ave Balto. 25 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19.55</u> , 19 <u>55</u> , to <u>1960</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-31-60</u> , 19 <u>60</u> , and that death occurred at <u>1145</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Stinchcomb</u>		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>5-31-60</u>	
PHYSICIAN'S NAME (Type) <u>Robert H. Stinchcomb</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burn</u>		22b. DATE THEREOF <u>3 June 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cems</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5381

CERTIFICATE OF DEATH

05365
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSMERE SHORES</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSMERE SHORES RURAL ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>(Dead on arrival) Anne Arundel General Hospital</u>				e. STREET ADDRESS <u>BAY VIEW DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DONALD I SWEANY SR.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-9-1905</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES REPRESENTATIVE MOTOR FGT. Co</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>BARUCH W. SWEANY</u>				14. MOTHER'S MAIDEN NAME <u>MARY RULLMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MARGUERITE B SWEANY #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertension on</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>4-20-1960</u> to <u>5-22-1960</u> , that I last saw the deceased alive on <u>5-22-1960</u> , and that death occurred at <u>10:24 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St., Annapolis, Md.</u>			
DATE SIGNED <u>5/23/60</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>MAY 24 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST MEN. CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHN M. TAYLOR, SONS ANNAPOLIS MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 24 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5382

CERTIFICATE OF DEATH

05366

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNVILLE		c. LENGTH OF STAY IN 1b 6 Mos. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNVILLE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 VOI. 4	
3. NAME OF DECEASED (Type or print) IRA First Middle THOMPSON Last		4. DATE OF DEATH 5 Month 21 Day 1960 Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 21/884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown laborer, unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	9. AGE (In years last birthday) 76 yrs.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown John H. Thompson		14. MOTHER'S MAIDEN NAME unknown Laura L. Gaines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Medical Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cause Cerebral Hemorrhage 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/25 to 5/26/60, that (I) (we) last saw the deceased alive on 5/21/60, and that death occurred at 4:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Lionel M. Henry Mapp		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lionel M. Henry Mapp, MD		22d. ADDRESS Crownsville State Hospital, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/1960	
23c. NAME OF CEMETERY OR CREMATORY Franklin Cem		23d. LOCATION (City, town, county) Churchton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John R. Williams		25a. REC'D BY REGISTRAR DATE MAY 25 '60	
ADDRESS 322 Schodack St.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CHRONIC STATE HOSPITAL 1105 West 20th St. St. Louis, Mo.
THOMPSON 2 21 60

Male 47 1894

Medical Record

General Hospital

Arterio-sclerotic cardiac disease
General Arterio-sclerotic

12/12 1902

12/12 60

General Hospital
Arterio-sclerotic cardiac disease
General Arterio-sclerotic

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
5325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 65367									
1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Roanoke				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis					c. LENGTH OF STAY IN lb 83X-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital					d. STREET ADDRESS 1338 Eastgate Ave., N. E.				
3. NAME OF DECEASED (Type or print) IRVIN C. THURSTON					4. DATE OF DEATH Month May Day 25 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 9, 1907		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME George Benjamin Thurston					14. MOTHER'S MAIDEN NAME Celia Haga				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Oakey Funeral Home, Roanoke, Va. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH PARTIAL	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Deceased stumbled and fell from houseboat into water.							
20c. TIME OF INJURY Month, Day, Year 8:30 P.M. 5/25/60		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Houseboat		20f. (City or town) South River Park- (County) Anne Arundel (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Wm. J. Tuckner					M.D. Wm. J. Tuckner				
EXAMINER'S NAME (Type) Wm. J. Tuckner					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED May 26, 1960				
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/30/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cem.		22d. LOCATION (City, town, or country) (State) Roanoke Co., Va.			
23. FUNERAL DIRECTOR Wm. J. Tuckner & Sons - Balto ADDRESS Med					24a. REC'D BY REGISTRAR May 31 '60		24b. REGISTRAR'S SIGNATURE William J. Tuckner		

MEDICAL CERTIFICATION

M

1

2

02

2

M

5383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a.d.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Brooklyn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 152 Edgevale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles T. Turner Sr.		4. DATE OF DEATH Month Day Year 5 26 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/24/84
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dock Builder		10b. KIND OF BUSINESS OR INDUSTRY McClellan Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Zachariah		14. MOTHER'S MAIDEN NAME Kate Nash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. FAMILY	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cardiac failure (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from Sept 12, 1958 to May 26, 1960 , that I last saw the deceased alive on May 26, 1960 , and that death occurred at 9:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED May 27, 1960			
ACTUAL SIGNATURE Y. K. YUAN M.D.		PHYSICIAN'S NAME (Type) Y. K. YUAN, M.D. 3810 S. Hanover St. Balt. more 25, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

03308

CERTIFICATE OF DEATH

2383



[Faint, illegible text and markings on the certificate form, including lines for name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>						d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First Middle Last </div> <u>THERESIA ANNA WAGNER</u>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month Day Year </div> <u>May 16 19 60</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Phillip Moritz</u>						14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-36-4507</u>		17. INFORMANT Address <u>Mr Charles Wagner- Son- same as # 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cr. Myocarditis,</u> <u>Auricular Fibrillation</u> DUE TO <u>Auricular Fibrillation, femoral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>right leg.</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural causes</u>									
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED				
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>May 19, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>						ADDRESS <u>Annapolis, Md.</u>			24a. REC'D BY REGISTRAR <u>MAY 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

P3930

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05370

5384

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Point Pleasant, Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>15 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On the ground, near Walt's Tavern, Point Pleasant Rd.</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carol Isaac Waltz</u>			4. DATE OF DEATH Month Day Year <u>May 3rd. 19 60</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/26/91</u>	9. AGE (In years last birthday) <u>68 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>19 60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carol County, Maryland.</u>	
13. FATHER'S NAME <u>John Preston Waltz</u>			14. MOTHER'S MAIDEN NAME <u>Mary Jane Reck</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT — Address <u>Mrs. Helen F. Wolf, 536 Alden St, Baltimore 25.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self inflicted wound to the head with a 32 gauge</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>revolver. (Harrington-Richardson make).</u> DUE TO (c) <u>Sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>See # 18</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>Unknown</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>On the ground</u>	
20f. (City or town) <u>Point Pleasant, G.B. A.A. Md.</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/3/60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 6, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Winfield Church of God</u>	
22d. LOCATION (City, town, or county) <u>Carroll Co., Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. WALTZ, Winfield, Maryland</u>			24a. REC'D BY REGISTRAR <u>MAY 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

NAME OF DECEASED JESSE		AGE 45		SEX Male	
DATE OF DEATH JAN 10 1901		PLACE OF DEATH Home		CITY Baltimore	
OCCUPATION None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
EDUCATION None		RELIGION None		MARITAL STATUS Single	
BIRTH DATE None		BIRTH PLACE None		PARENTS None	
SPOUSE None		CHILDREN None		SIBLINGS None	
PREVIOUS ILLNESS None		TREATMENT None		HISTORY None	
SIGNATURE OF EXAMINER None		DATE None		PLACE None	

RECEIVED
JAN 10 1901
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5327

CERTIFICATE OF DEATH

05373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle E. Last WHITWORTH		4. DATE OF DEATH Month May Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1903
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN WESTLEY COLE		14. MOTHER'S MAIDEN NAME MARY E HARDESTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ROBERT G WHITWORTH #2	
17. INFORMANT ROBERT G WHITWORTH #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FIBROSIS DUE TO 5 JSSX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 9, 1960 , to May 3, 1960 , that I last saw the deceased alive on May 3, 1960 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 71 Franklin St., Annapolis, Maryland DATE SIGNED May 6 '60			
ACTUAL SIGNATURE Edward S. Beck		M.D. 71 Franklin St., Annapolis, Maryland	
PHYSICIAN'S NAME (Type) Edward S. BECK		Ann timer	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-7-1960	
22c. NAME OF CEMETERY OR CREMATORY ASBURY CEM.		22d. LOCATION (City, town, or county) (State) ARNOLD MD	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR-SONS		ADDRESS ANNAPOLIS MD	
24a. REC'D BY REGISTRAR DATE MAY 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

5385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Jane Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. 9.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salesville</u>		c. LENGTH OF STAY IN 1b <u>lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William B. Waters</u>		4. DATE OF DEATH <u>May 27 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1888</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
12. BIRTHPLACE (State or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Unknown</u>		15. MOTHER'S MAIDEN NAME <u>Unknown</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		17. SOCIAL SECURITY NO. <u> </u>	
18. INFORMANT <u>Carrie Waters, Salesville Md</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Dehydration & starvation (mal-nutrition)</u> 150X DUE TO <u>Carcinoma of esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>one month at least 3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1960</u> to <u>May 27, 1960</u> , that I last saw the deceased alive on <u>May 26, 1960</u> , and that death occurred at <u>7 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Spady Side, Md.</u> DATE SIGNED <u>5/30/60</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-31-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cherios Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>		ADDRESS <u>Anna, Md</u>	
24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAY 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FLORIDA DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

5385

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

When Filled In

MADE FOR COUNTY

MARYLAND

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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Copyright, 1900, by the State of Maryland. All rights reserved. This certificate is to be filled out by the physician or other person having knowledge of the facts of the death, and is to be filed with the local health officer. It is not to be used as a certificate of death for legal purposes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5386

CERTIFICATE OF DEATH

05372

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 822 N. Carrollton Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Benjamin Franklin Watson				4. DATE OF DEATH Month May Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1872	
9. AGE (In years lost birthday) 88 yrs.		10. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Clerk				10b. KIND OF BUSINESS OR INDUSTRY Banking			
13. FATHER'S NAME James W. Watson				14. MOTHER'S MAIDEN NAME Sarah Henson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. 578-28-0502		17. INFORMANT Rev. V.T. Key Address 822 N. Carrollton Ave. Balto. 17	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 443X (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 3, 1960 to May 25, 1960 , that (I) (we) last saw the deceased alive on May 21, 1960 , and that death occurred at 12:01 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James M. Pair				22b. DATE SIGNED May 25, 1960		22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.	
22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Mr. Frances A. Hunsley Biddle				25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

(I)

05333

CERTIFICATE OF DEATH

05333



NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

REGISTRATION NO. [illegible]
MUNICIPALITY: [illegible]
DISTRICT: [illegible]
STATE: [illegible]
DATE OF REGISTRATION: [illegible]
OFFICIAL SEAL: [illegible]

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05374

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS P. O. Box 455			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLENE ELIZABETH WITSIL				4. DATE OF DEATH Month Day Year May 3 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1945	
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Jr. High		11. BIRTHPLACE (State or foreign country) Hope, Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles P. Witsil Jr.				14. MOTHER'S MAIDEN NAME Elizabeth Robinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Charles P. Witsil Jr. Father; Same as # 2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease (Malformation of Interventricular Septum) DUE TO (b) 7545 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty, M.D.				DATE SIGNED 4/3/60			
EXAMINER'S NAME (Type) Charles S. Petty, M.D.				DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Wilmington & Brandywine Cemet.		22d. LOCATION (City, town, or country) (State) Wilmington, Del	
23. FUNERAL DIRECTOR HOPPING FUNERAL HOME				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR MAY 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

05334

100-100000



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James A. ...

M

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James A. ...

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5329

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>15 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Arnold Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>			d. STREET ADDRESS <u>Rt. 1 Box 119</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>L.</u> Last <u>Wolfe</u>			4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/1894</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buoy Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Wagerstown Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MARRIAGE NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>			
16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Mrs Ethel M. Wolfe</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage with hemiplegia, left</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arterio sclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> to <u>May</u> , 19 <u>60</u> that I last saw the deceased alive on <u>May 29</u> , 19 <u>60</u> , and that death occurred at <u>9:30 P.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Francis I. Codd</u>		ADDRESS (Street, city or town, state) <u>P.O. Box 289</u> DATE SIGNED <u>MAY 31 '60</u>			
PHYSICIAN'S NAME (Type) <u>Francis I. Codd, M.D.</u>		<u>Severna Park, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Helen Haven Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

10375

CERTIFICATE OF DEATH

329

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 6264 6-7-60 et

5387

CERTIFICATE OF DEATH

05376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Stearns	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Linthicum		c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Stearns	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 429 Shipley Rd.		d. STREET ADDRESS Stearns	
3. NAME OF DECEASED (Type or print) Rome First Estes Middle Youngs Last		4. DATE OF DEATH May 25 1960 Month May Day 25 Year 1960	
5. SEX m	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11:30 PM 5/17/87 Month May Day 17 Year 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Building Home Storage Pa.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Stephen W. Young		14. MOTHER'S MAIDEN NAME Alice Sprigg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 11:30 PM	
17. INFORMANT Larry L. Young		Address Stearns	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Cancer of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 14 mo. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 - 1960 , to 5/25 1960 , that I last saw the deceased alive on 5/25/60 , 19 60 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. L. Ball		DATE SIGNED 5/25/60	
PHYSICIAN'S NAME (Type) Charles L. Ball, M.D.		Linthicum, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/29/60	
22c. NAME OF CEMETERY OR CREMATORY Maple Grove		22d. LOCATION (City, town, or county) (State) Shinglehouse, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE James Hopping		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

